Ensure Equality of Access to Treatments for All Cancer Patients

**ISSUE BACKGROUND**

Oral drugs have become the standard of care in cancer treatment of many types of cancers. The National Comprehensive Cancer Network (NCCN) Drugs and Biologies Compendium is used by the Centers for Medicare and Medicaid Services (CMS), as well as many private health plans, to develop its oncology coverage policies. The compendium includes many oral anti-cancer treatments. For instance, an oral therapy is listed as the preferred therapy for breast cancer for invasive, metastatic, HER-2 positive patients who have failed on prior IV therapies. An oral therapy is also listed as the primary treatment in the chronic myelogenous leukemia guidelines. Oral temozolomide is the current standard of care for first-line management of glioblastoma multiforme, a primary malignant brain tumor.

Insurance coverage has lagged behind the rapid growth in oral anti-cancer medications. As oral cancer treatments have become more readily available and the standard of care in many cases, the coverage structure has not adapted to address these changes.

Health care plans use different cost-sharing strategies to help control their costs, such as deductibles, co-insurance, and limits on coverage. Cost-sharing is intended to sensitize patients to the financial consequences of their choices and encourage patients and physicians to choose less expensive and generic drugs. However, the strategy of using cost-sharing to help patients make good, cost-effective choices doesn’t work as intended when dealing with anti-cancer medications, where options are limited. Decisions should be based on what is considered the most effective treatment in these cases, not just what is the most affordable.

Intravenous (IV) and injected treatments were once the primary methods of cancer treatment. However, oral treatments have become more prevalent and are the standard care for many types of cancer. The coverage structure has not kept up with this trend. Many of these drugs are effective in cancer treatment, and often don’t have IV or injected alternatives. There are 40 oral anti-cancer

**REQUEST**

Enact HR 2746, the *Cancer Coverage Parity Act of 2011* to require coverage parity for anticancer regimens regardless of delivery method including, but not limited to oral and intravenous drugs, injections, surgery, radiation, transplantation, etc.
medications that are Food and Drug Administration (FDA)-approved, only nine of which have less expensive generic equivalents.

Oral anti-cancer medications are very expensive. These drugs can run as high as $10,000 per month. Though intravenous and injected medications can be as expensive or even more expensive, higher cost-sharing required of patients for oral medications makes them much less affordable. When an oral treatment is determined most effective, patients are sometimes forced to make their treatment choice based on cost, rather than efficacy. This can be a large financial burden on patients and potentially a life or death decision.

**PEAC Position**

Every cancer patient should have access to the treatments recommended by their physicians. The Patient Equal Access Coalition (PEAC) believes that patients should not suffer from cost discrimination based on the type of therapy provided or the mechanism for the delivery of that therapy. *Therefore, PEAC calls on Congress to enact HR 2746 to require coverage parity for anticancer regimens regardless of delivery method including, but not limited to oral and intravenous drugs, injections, surgery, radiation, transplantation, etc.*
Cost Effectiveness of Oral Chemotherapy

Many exciting advancements are being made in cancer treatment and care that are allowing us to selectively target cancer cells and deliver agents that directly interfere with the cancer cells’ survival. These targeted agents generally require continuous exposure to the medication, for which oral therapies are well-suited. Today, oral oncology therapies comprise about 10% available therapies. It is estimated that 25-35% of the medications in the oncology development pipeline are oral therapies. This will result in an increased number of options for patients, but antiquated health insurance benefit designs currently can create burdens to patient access of these oral therapies. Studies have found examples of where oral anti-cancer drugs are less expensive to the insurer than their IV or injected alternatives. Below are some examples:

- In many cases oral chemotherapy appears to be more cost effective than Intravenous chemotherapy (IV). Associated Costs for Tarceva for lung cancer patients are estimated to be $20,042 as compared to $20,630 for the IV alternative. For metastatic breast cancer patients the cost of oral chemotherapy is $35,842 annually compared to $43,353 for IV Chemotherapy.

- The number of visits for initial care follow-ups and potential complications is substantially fewer for oral chemotherapy than for IV chemotherapy. For colon cancer patients taking Xeloda, the average number of visits for care is 8 compared to 30 for those patients receiving the IV alternative.

- 10 % of the cost for IV chemotherapy drugs cost comes from administrative expenses including the nurse and doctor’s time.

- One study found that the cost to expand coverage to include oral chemotherapy for most benefit plans is under $0.50 Per Member Per Month (a mere 0.17% increase in the typical benefit plan of $300 Per Member Per Month).

- A study by Prime Therapeutics found that one in six cancer patients with high Out of Pocket (OOP) costs abandon their medication. The study also found that patients with an OOP greater

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1 Milliman Client Report “Parity for Oral and Intravenous/Injected Cancer Drugs
2 Journal of Medical Economics. 2009 Volume 12 No 3. Cost of oral capecitabine compared to intravenous taxane-based chemotherapy in first line metastatic breast cancer
3 Dentalplans.com “Xeloda should replace burdensome Intravenous Chemotherapy” 5/19/2005

The Patients Equal Access Coalition (PEAC) is a patient focused coalition of organizations representing patients, health care professionals, care centers, and industry collaboratively joined together whose mission is to ensure that cancer patients have equality of access (and equality of insurance coverage) to all approved anticancer regimens including, but not limited to oral and intravenous drugs, injections, surgery, radiation, transplantation, etc.
than $200 were at least three times more likely to not fill their prescription than those with OOP costs of a $100 or less. The study suggests higher OOP costs for these oncology medications negatively impact patient health as well as long-term health care costs.

- Oral oncology medication monthly OOP costs averaged $2,942 in 2009, up 17% from 2008.
- With IV chemotherapy, the financial burden for patients doesn’t stop with direct medical costs. Patients lose work time to go to chemotherapy treatment. Usually, a friend or family member must also lose work time to transport the patient to treatment. Indirect costs also include loss of time and economic productivity resulting from cancer-related illness and death. The National Institutes of Health estimated lost productivity due to premature cancer deaths in the United States in 2005 at $134.8 billion (estimating about 600,000 cancer deaths that year).

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State Anti Cancer Medication Parity Laws

State legislatures around the nation are taking action to ensure access to all cancer therapies. Oregon enacted the first oral cancer drug parity law in 2007. Since 2007, twelve states and the District of Columbia have passed anti cancer medication parity legislation. New Mexico and New Hampshire have passed laws requiring further study of the issue. Currently, there are 13 states working to pass similar legislation this year including, California, Missouri, Ohio, Oklahoma, South Carolina, Tennessee, and Wisconsin.

Oral Chemotherapy Access Legislative Landscape - August 2011

- - Introduced in 2011
- - Passed prior to 2011
- - Passed-Signed in ’11
- - Waiting Gov. Action


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